Name: Anonymous
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Organization or Agency:
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Testimony:
The word trauma seems to have become one of those trendy buzz words-you hear it everywhere, tossed about with such frivolity that its seriousness has been diluted. The result: real people who truly suffer from its multidimensional and continued debilitation all too often go without the treatment they so desperately need. I know because I am steeped in trauma's aftermath.
Incarcerated people are forced to live in a hypervigilant state, knowing anything can "pop off" at any time. At any moment, our fear-conditioned response – fight, flight, or freeze – may need to be employed. The feared danger comes from both directions, peers and staff. Conflict between residents is not like "must see TV"; it is much more human than that. In a women's facility, most disputes among the residents arise because of perceived threats to relationships. The majority of the population here are survivors of sexual assault and\or domestic violence. Lack of treatment leaves them devoid of any interpersonal skills. Healthy relationships are a foreign language because love, violence, and trauma are braided together in a very tempestuous and destructive way. Here, physical violence translates to "I love you". I cannot count the amount of "fights" I have seen erupt over pseudo "domestic" relationships.
The correctional officers also keep us in this very damaging hypervigilant state. Some are unaware, others intentionally inflict harm. Male officers, for example, will often flip their handcuffs or jingle their keys around when touring the unit - a signal to women that a man is "on the tier". For us, because these items are used when taking us to segregation or worse, the mental health unit (MHU), it is an automatic cortisol surge that takes twenty minutes from which to recover. Daily, the threat of random and overused full cavity strip searches, unannounced room searches where contraband is not only found, but is sometimes planted, and the use of segregation as punishment for subjective infractions is business as usual. The bottom line is we NEVER feel safe. The residual impact of all of this? The often untreated and self-medicated trauma we entered the facility with, in prison, becomes exasperated.
Worse still is the response from staff when we are experiencing the effects of trauma. I have avoided ever going to MHU, despite my history and diagnosis of severe and chronic post-traumatic stress disorder, in large part because of the horror stories I have heard about the so-called treatment that is administered there. Instead, I struggle silently and white knuckle my way through every aspect of my day. It is exhausting. Others have not been so fortunate. This is Jayla's story.
Jayla was involuntarily placed in MHU for a suicide watch, which consisted of a strip search and being fitted with a flimsy paper gown that tore a little each time she moved. Placed in a barren cell chilled to near freezing temperatures, the room contained nothing but a platform equipped with an apparatus to apply four-point restraints, a stainless steel toilet/sink combo, a drain, and bugs. Lots of them. Aside from two rough body-odor infused poor excuse for blankets, she was not permitted to have any item in her possession - not a bra, a toothbrush, eyeglasses, a book, nothing. She was menstruating and was not allowed to have a tampon or a sanitary napkin, or a pair of underwear for that matter. Her only options: to bleed down her leg, to dab at the blood with the allotted four squares of toilet paper, or to sit and drip on the metal toilet, all of which would be witnessed by the male officer seated at her door. Through the large plexiglass observation window, he also watched her pace, sob, sleep and defecate. The light, which could only be operated from outside the locked cell, was on 24-hours per day. There were foreign and terrifying sounds and smells--all of which overloaded her senses. Fast forward several years, when Jayla was no longer on suicide watch and now a multipurpose worker on the compound. She recounted "one day, the captain of MHU asked me to come to the unit to paint the doors. Arriving with my paints and

brushes, I was prepared to work. But as I approached the first door, I froze. I could not breathe. My palms broke out into a sweat. The sound of my beating heart drowned out all else. I felt woozy. I was having a full blown panic attack. This, after having been discharged from the unit a decade earlier". Needless to say, she hid her trauma response for fear it would send her back to MHU. Jayla's experience is not isolated. Sadly, it is very common here, and within all of the other correctional facilities.

MHU is also used in cases of self-injurious behavior. It is referred to as staggered observation (SO). Translation: constant monitoring. Meet Elle. She was placed on this status, for six weeks, following an episode of "cutting". She explained that the worst part of SO is lack of mental stimulation. "You are not allowed books or anything to distract the mind. This exacerbates an already anxious or depressed condition. All I could do is watch the bugs crawl from the drain in the center of the room". She told me she once observed a woman across the hall from her, who was also on SO status. The woman had defecated on the floor of her room and smeared herself with her feces. Did I mention that no clothes are allowed on SO? As a result, this woman had rubbed her feces on the front of her chest and her face; she also put it on the windows and walls. At meal time, the correctional officer pushed bologna sandwiches through the trap door for her, but she would stick them on the window instead of eating them. The staff responded to her actions by refusing to feed her for a few days. She was left her in the filthy cell for seven days without a shower or medical staff checking her status, perhaps because the cell was in such deplorable condition.

These are just two accounts of the hundreds I have been told about over the years. Trauma effects responded to with more trauma. It is a vicious cycle.
Over the years, I have learned--and witnessed-- how trauma changes people. Not only psychologically but physically as well.

I wish I had understood that years ago. I was sexually assaulted as a child and lived in a home that could never have supported the weight of that trauma, if I ever dared speak it out loud, but I did not. At eleven years old, alcohol helped me survive and stay numb. It also put me in situations replete with danger and further traumas. My body saved those screen shots and taught my brain to escape, to protect itself, at all cost. The cost has been beyond measure. I am, after all, here.

I make no excuse for my choices, and any attempt at an explanation is both complex and inconsequential. I am sure we have all said at one time or another "I wish I knew then what I know now", and this is certainly true for me. Time, education, and introspection have taught me how interconnected trauma, psychology, and biology are. More importantly, I learned how treatment, or lack thereof, create outcomes for better and for worse.

To be fair, Corrections does have a policy to assess "offenders" upon arrival. However, because the population continually increases, proficiency inevitably decreases. Everyone receives a ten minute intake interview by a social worker to determine any "emergency" mental or physical needs. If none are determined at processing, it can take up to thirty days to be seen by a psychologist, for what we refer to here as "a drive by diagnosis ". We call it that because no substantive evaluation takes place in the mere minutes that we are allotted to speak to a mental health professional. Instead, after listing our symptoms, the preferred course of action is chemical treatment. Residents are prescribed any number of cost-effective over person-effective drugs. If a resident is on medication, her assigned social worker is required to see her only once per month for fifteen minutes. That is the extent of the “therapy” provided in this facility. No trauma treatment!

Prison has become the new psychiatric institution. Many of its residents pose more danger to themselves than the public. How can we ever correct the growing problem of over-incarceration when the institution itself further causes, not cures, the trauma from which its occupants suffer. Changing outcomes in the future must be a priority of policymakers. By allocating funds to provide those in power, our Attorneys,

Judges, Correctional, Parole, and Police Officers with trauma-informed treatment education, we can begin the arduous process of meaningful change. Most of us currently incarcerated folk will be rejoining your neighborhoods in the future. Preparing us for that return, using science-based trauma treatment, just makes good sense. This implementation is crucial if we are to break the cycle, reduce trauma-associated criminality and recidivism, and most importantly, heal the people who so desperately need it.